Behavioral Health Subcommittee Meeting

Meeting Minutes: 12/16/2015

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Jerilyn Church, Amy Iversen-Pollreisz, Terry Dosch, Dr. Dan Heineman, Steve Lindquist, Betty Oldenkamp, Dr. Matt Stanley, Alicia Collura, Sandra Fortuna

Welcome and Introductions

Don Novo from HMA opened the Subcommittee meeting. A roll-call was conducted to identify the subcommittee members that attended the meeting via audio conference.

Review December 4 Minutes

Don asked the subcommittee members to review the minutes of the December 4th meeting (http://boardsandcommissions.sd.gov/Template.aspx?id=145) and to submit any changes, revisions, or comments for revision into the final meeting minutes to them to Kelsey Smith at Kelsey.smith@state.sd.us

December 4th recap of the Behavioral Health Subcommittee meeting:

The Behavioral Health Subcommittee discussed the following topics at their December 4th meeting:

- Presentation on Substance Abuse services funded by Medicaid and other sources
- Great Plains Tribal Chairman's Health Board presentation of their Access to Recovery program
- Capacity for IHS participation in the Medicaid Behavioral Health-Health Homes program
- Overview of Tele-Psychiatry and use in the Medicaid program
- Development of Subcommittee recommendations for the December 16th Coalition meeting

Follow up from Last Meeting Regarding Medicaid Tele-health Services/Billing

Lynne Valenti provided follow-up information on questions from the previous meeting.

Question: May a telephone conversation be reimbursed as telemedicine?

Response: No. Both Medicaid and Medicare require that telemedicine must constitute two-way, real-time communication between the patient and the provider. The equipment must include both audio and visual components.

Question: May telemedicine be reimbursed for providers located in the same community (e.g., individual residing in a skilled nursing facility needs a consultation with a specialist or physician in the same community)?

Response: Medicare requires that the tele-medicine originating sites be located in health professional shortage areas or a county outside of a metropolitan statistical area. Medicaid does not have any statutory limitations. The State can use Medicare requirements or develop its requirements, such as using telemedicine for individuals who are in long-term care facilities.

Question: May other types of provider's bill for telemedicine delivery – pharmacists, individual behavioral health practitioners?

Response: Today, Medicaid only allows specific provider types to bill (e.g., physician, physician assistant, nurse practitioner, nurse midwife, clinical nurse specialist, certified registered nurse anesthetist, clinical psychologist, clinical social worker, registered dietician). Medicaid requires providers be recognized Medicaid providers (must be enrolled as a provider who can bill Medicaid directly). This would disqualify pharmacists, for example. Other providers, such as independent mental health practitioners, are limited by the codes available to bill via telemedicine. For example, for psychotherapy codes are currently not billable to Medicaid when provided via telemedicine.

Question: How was reimbursement for the facility fee set (some providers perceive the fee is too low to cover the telemedicine costs for space and administration)?

Response: Medicaid does allow reimbursements for some additional TeleHealth costs, such as technical support, transmission charges and equipment as add-ons; however, total costs reimbursed must not exceed the costs of providing the same care to the patient face-to-face (including any non-emergency transportation costs). These are the factors that the State considers when setting rates.

Anticipated Need for Substance Abuse Services for the Expansion Population

Amy Iversen-Pollreisz presented information about the State's expectations regarding what level of substance abuse treatment services the expansion population might need. The presentation deck can be found on the State website at *boardsandcommissions.sd.gov*.

If the state were to expand Medicaid, 36,400 individuals who are currently Medicaid eligible would become eligible for Medicaid funded substance abuse services. This plus the projected expansion population of 54,693 constitutes the total population that would become eligible for Medicaid funded substance abuse services. It is estimated that approximately 11.2% are expected to need substance services- or about 10,202 individuals. Currently, 7,274 of these individuals are already receiving some substance use treatment services through non-Medicaid federal and state funding. This number leaves 2,928 of the expansion population who is expected to need substance use services and would be new to the system. The State will have to identify additional provider capacity needed to support the projected needs of the newly eligible individuals, particularly since the providers noted in the presentation do not include Tribal providers not currently enrolled inthe Medicaid program.

The group discussed that the State also will want to look at what providers are currently offering services that are NOT covered by Medicaid today. The other consideration will be the federal Institution for Mental Disease (IMD) exclusion as these facilities do not qualify for Medicaid payment. There also was an acknowledgement that making the proposed changes will be a challenge because the State will have to define what services can be covered by Medicaid and develop sustainable funding mechanisms for the full continuum of services, including those that Medicaid will not cover. The group consensus is that priority should be to ensure that substance abuse services currently provided, regardless of Medicaid or other funding, should be provided to both the current and expansion population.

Substance Abuse services that are eligible today under South Dakota's Medicaid State Plan are currently extended to only adolescents and pregnant women. These services would be available to the entire Medicaid population should the state expand Medicaid to the new adult group.

- *Outpatient services*
- *Day treatment, treatment services only* (16 beds or less); housing components of day treatment are not eligible for Medicaid billing but treatment component is eligible for Medicaid reimbursement.
- *Halfway house/low intensity treatment, treatment services* (16 beds or less) residential component is not eligible for Medicaid billing but treatment component is eligible for Medicaid reimbursement.
- *Inpatient treatment* (16 beds or less)
- Detox services are NOT Medicaid eligible

Discuss Capacity for IHS and Non-accredited Tribal Programs for Substance Use Disorder Services

Jerilyn Church said they were conducting a survey with Tribal providers on their substance use treatment programs. They will be asking about services, the types of providers on staff, and the number of individuals served. The survey will provide a more comprehensive overview of substance use services available through Tribal providers. This information will help inform the provider capacity for provision of these services to determine if any gaps exist for various services.

Review of Subcommittee Recommendations

The group reviewed the Behavioral Health Subcommittee's recommendations to date. An important part of the discussion for all recommendations is ensuring there is funding to cover the costs of any provider or service expansions. There are two key opportunities to funding these kinds of changes; 1) if CMS allows more services to be matched at the 100% FMAP rate than South Dakota originally anticipated, which can free up more state general fund dollars than expected; and 2) the State's experience with expansion costs less than the projections used in the State's estimates (which deliberately have been very conservative). This will require incremental implementation of most recommended changes, to ensure that they are prioritized, and the State can pay for them as they are implemented.

1. Expand capacity through Indian Health Services and Tribal Programs
   i. Behavioral Health Health Homes

   ii. CMHC services

   iii. Substance use treatment services

   This recommendation includes funding technical assistance for IHS and Tribal programs to understand how to work on the specific requirements and infrastructure development required to implement programs. It also would include incorporating Community Health Workers and Community Health Representatives (CHW/CHRs) as part of the Health Home model (per recommendation from the New Services Subcommittee), as peer support specialists for behavioral health, and building a formal CHW/CHR program under Medicaid.

For each of the components of this recommendation, there will need to be an additional analysis of the expected costs. Medicaid covered services provided through Indian Health Services or tribal programs operating 638 programs are funded with 100% federal funds through Medicaid so that makes this recommendation more affordable. The State will work to identify and prioritize how to support any new/additional services that are not covered by Medicaid, but part of the continuum of care, by maximizing what can be paid for by Medicaid first and leveraging any savings for additional services.

Existing Community Mental Health Center and Substance Abuse providers have offered to provide technical assistance to IHS and Tribal providers to help them achieve the necessary accreditation and level of services to become CMHCs and Behavioral Health Health Homes. The focus will be to maintain the high-quality services provided through these programs today, and expanding access to those services to more individuals. This work should start today, regardless of the discussion around Medicaid expansion, because these services can be expanded to existing eligible populations as these services are eligible today for 100% federal match. Jerilyn Church noted that the Great Plains Tribal Chairman's Health Board (GPTCHB) has made the request of IHS to partner and collaborate on meeting some of the requirements to become CMHCs and Behavioral Health Health Homes.

2. Expand who is a Medicaid eligible provider of behavioral health and substance use treatment services.

   This recommendation includes expanding who can be an eligible provider of behavioral health services under Medicaid to determine if there are options to expand to additional provider types (for example, private providers who may not be associated or providing the service through a specific clinic).

   The State estimates that there currently are about 100 individuals working under supervision to become LPC-MHs. Additionally, Licensed Marriage and Family Therapists' training and education align closely with LPC-MH education and training, so these two groups of providers are a good place to start for expanding the behavioral health provider base. Both of these professional groups require Master's degree-level education. However, adding new providers will have a fiscal impact, and the State will need to review the expected costs. The subcommittee members support this approach noting that this will allow in incremental steps increased capacity and supports consistent application of Medicaid provider qualifications.

3. Adding evidence-based services and supports for Children and Families, including supporting the provision of Functional Family Therapy (FFT) as a Medicaid state plan services.

   The State has worked hard to promote evidence-based models that offer effective treatment for both individuals and families. There are some providers in South Dakota today piloting Functional Family Therapy programs. There will need to be more analysis of how to structure the payment model for this type of service under Medicaid, particularly since the program is very structured and has specific staffing requirements. The State also will need to evaluate whether the program can be implemented in Indian Country, because of the significant infrastructure and staffing requirements.

The group noted that the spectrum of care question regarding options for providing services in less intensive settings require prioritization as a way to ensure the State can more effectively and quickly meet existing access and service needs. While there is good evidence of the efficacy of the FFT program, it will take a lot longer to implement and require more intensive effort than some other services that can be set-up more quickly and also can have a big impact on patients.   The group concurred that leveraging federal funds is a strategy that should be pursued.

The group also discussed behavioral health day treatment (also known as partial hospitalization) services. Some capacity for this service exists today. For the purposes of using Medicaid, the federal regulations are fairly prescriptive relative to staffing qualifications and levels and would need to be considered as this service is considered. The recommendations will reflect further exploration of this as well as school based services.

4. Explore the ability to expand the use of tele-health in behavioral health and substance abuse services through consideration of additional providers and additional services eligible for Medicaid reimbursement.

   The group agrees that the part of this recommendation focused on ensuring access to existing services should be folded into the Access Subcommittee's recommendation to expand TeleHealth emergency and specialty services to IHS and Tribal providers. The specific recommendation from the Behavioral Health Subcommittee then should focus on exploring opportunities to use Telehealth for services and providers not currently eligible to bill Medicaid via telehealth. . The group also recommended consideration of permitting telemedicine to be utilized within nursing facilities.

   Workforce development is a critical need; the additional 2,928 new individuals will impact the system. One area of priority could be identifying additional ways to use telemedicine to support providers and programs. For example, in addition to LPC-MH staff, there is a need for Addiction Counselors to support substance use disorder treatment.

5. Analyze the cost of coverage of substance abuse services to the expansion population and the resulting potential savings to the federal and general funds that will occur and options for reallocating those savings.

The group agreed that this should be a priority and that this will be essential to determine if funding could be leveraged within the existing budget and should focus on the ability to support non-Medicaid funded services for the new expansion population.

Priorities Discussion

Kim Malsam-Rysdon noted that Recommendations; 1 (expand capacity through IHS and Tribal programs) and 5 (analysis of the cost of coverage for substance use services for the expansion population) are essential "must dos," so are the starting point for the recommendations. The group agreed. The group further agreed that the remaining recommendations were in priority order – 2, 3 and 4.

Next Steps:

- Today's Behavioral Health Subcommittee discussion will be shared with the larger Coalition, which meets at 1 PM this afternoon.
- Jerilyn Church is working on a Tribal Provider Survey for substance use treatment services; she will share the results of that survey with the group as soon as available.
- DSS will develop an interim report outlining the subcommittee and Coalition recommendations, to give to the Coalition before their January 6th meeting.
- The DSS will develop a strategy for beginning work on the implementation of recommendations that can be started now. The Behavioral Health Advisory Council has been used in the past to support building and implementing new services, and the group agreed the Council should take over continuing the Behavioral Health Subcommittee work. The Council is comprised of providers, consumers, and other stakeholders and regularly meets in support of Medicaid behavioral health programs and services. The group agreed with this approach and also noted that it would be helpful to add some of the Behavioral Health Subcommittee members to the Council, as well as subject matter experts to help flesh-out some of the specific operational issues, as needed.

Closing Remarks

Kim Malsam-Rysdon and Lynne Valenti noted that the Governor's Office and Department of Social Services are committed to ensuring that all the individuals on the Behavioral Health Subcommittee will continue to be informed about what is developing as the State moves to implement their recommendations. They also expressed great appreciation for the group's knowledge, expertise, and dedication to finding solutions to improving care for vulnerable populations.

REMINDER:

- All the materials from the Coalition and Subcommittees is available at: (http://boardsandcommissions.sd.gov/Template.aspx?id=145)